

Palmetto State Providers Network
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July 30, 2010

Subject: Rural Health Care Support Mechanism - Notice of Proposed Rule Making Response

These responses are to the Federal Communications Commission in the Matter of the Rural Health Care Support Mechanism (WC Docket No. 02-60) Released July 15, 2010. Responses are listed in read and appear after the sections of concern and comment.

III. HEALTH INFRASTRUCTURE PROGRAM

18. *Build-out Period.* We propose that participants have a period of three funding years (commencing with the funding year in which the initial online application was submitted) to file all forms and supporting documents necessary to receive funding commitment letters from USAC; and a period of five years (commencing on the date on which the participant receives its first funding commitment letter for the project) in which to complete build-out.¹

The three funding years should be allocated such that upon approval of the RFP solicitation and grant award, there is sufficient funding for the initial phases of the construction. In our RHC Pilot Project, we did not have sufficient funds to encumber for the entire build out nor some Monthly Recurring Costs. Specifically, there needs to be flexibility in the draw-down (commitment) amounts and dates of the draw-downs. There should be the ability to encumber funds from the next budget periods of the award when the need it demonstrated. A three year allocation of funds may be appropriate, but the ability to use more than one year of funding at a specific period prohibits the speed of a build-out when possible.

B. Provisions Applicable to Initial Application for Funding

1. Demonstrated Need for Infrastructure Funding

19. *Connectivity Speed.* We seek comment on setting a minimum threshold for broadband connectivity speeds under the health infrastructure program. The National Broadband Plan suggested that most businesses in the United States, including health care providers, have two choices of broadband service: mass-market, small business solutions of 4 Mbps or more, or dedicated Internet access (DIA) solutions of 10 Mbps or more.² Because the focus of the health infrastructure program is to fund dedicated networks, we propose setting 10 Mbps as the minimum broadband speed for infrastructure deployment supported under the health infrastructure program.³ We seek comment on this proposal. We also seek comment on minimum levels of reliability, including physical redundancy, to support health IT services and what can

¹ See Appendix A, 47 C.F.R. § 54.650(e). For example: An applicant submits an initial application on July 1, 2011, and is notified of project eligibility on January 1, 2012. This applicant would have three funding years, ending on June 30, 2014, in which to complete all application materials, conduct competitive bidding, select vendors, and request funding commitment letters from USAC. If such applicant receives its first funding commitment letter for a project on July 1, 2012, it would have to complete build-out for the project by July 1, 2017.

² National Broadband Plan at 211; see Internet2 June 25, 2010 *Ex Parte* Letter, at 2-3 (bandwidth requirements for telemedicine applications can vary from 10.8 Mbps to as high as 20.4 Mbps).

³ See Appendix A, 47 C.F.R. § 54.631(e).

be done to encourage reliability.⁴ We also seek comment on the minimum quality of service standards necessary to meet health IT needs. We seek comment on whether the health infrastructure program should contain a minimum quality of service requirement.⁵

PSPN agrees with the assessment that healthcare providers generally require connections with a minimum of 10 Mbps to meet the current requirements for video and imaging transmissions. In addition we propose that the bandwidth provided on these circuits should be configured to deliver multiple services with bandwidth allocations made based on applications and individual facility requirements,

By constructing the network in a virtual cloud configuration, healthcare providers can use single, high-quality circuits to access Internet, Internet2, NHIN servers, etc. and to establish very secure point-to-point connections between each other. The elimination of single purpose connections will result in significant savings and reduce network complexity. Using the cloud approach enables any-to-any connections but requires quality of service assurances to properly manage key functions across the network.

We propose that healthcare networks should be designed to deliver sensitive, high-priority traffic in a WAN configuration and without using the public Internet where possible. By lowering dependence on the public Internet healthcare networks may realize better protection from large scale cyber attacks, lower overall costs for Internet use and better performance on key functions like HD video, imaging, etc.

While we agree 10 Mbps should be the minimum bandwidth for provider locations, we also have found that many locations have much higher bandwidth requirements. Infrastructure build-outs should be constructed to easily allow healthcare providers to increase bandwidths as demand grows without having to reconstruct the network or make excessive upgrade expenditures.

In addition, as healthcare providers become increasingly dependent on connections to external databases, telemedicine applications and other facilities to function, many locations will require redundant connections to ensure continuity of service in the event of a connection outage. We believe funding should be available for these types of connections as they become an essential part of healthcare IT infrastructure. Unprotected circuit connections should maintain reliability standards of at least 99.9% while protected circuits should feature reliability standards of 99.99%.

Finally, the HITECH program calls for the secured transmission of PHI and other sensitive data by a federated trust, NHIN. To gain access to the NHIN, without undue expense to the HCP, the network should provide a network based NHIN transmission of PHI and other sensitive data by a federated trust, NHIN. To gain access to the NHIN, without undue expense to the HCP, the network should provide a network based NHIN server. The FCC will need to provide access to Federal partners to the networks which will support the access to open and free NHIN servers on the Rural Health Care Support Mechanism

23. The National Broadband Plan also suggested that health care providers could justify funding from an infrastructure program by providing a financial analysis showing that the cost of new network deployment would be significantly less expensive over a specified time period (e.g., 15-20 years) than purchasing services from an existing network carrier.⁶ We seek comment on whether we should adopt such criteria,

⁴ See Internet2 June 25, 2010 *Ex Parte* Letter, at 1 (suggesting that funded services should include minimum standards of quality of service, including reliability, bit relay, jitter, packet dropping probability and/or bit error rate).

⁵ See *id.*

⁶ National Broadband Plan at 215.

in addition to the three options proposed above, and, if so, what should be included in the financial analysis? If we require that applicants demonstrate that network deployment would be less expensive over a period of time, what period of time is appropriate? For example, should such period of time be equivalent to the useful economic life of the funded network? Should an applicant provide a net present value to demonstrate cost effectiveness? Are there other methodologies that can be included in a financial analysis to demonstrate the cost effectiveness of network deployment?

There are many factors that would impact a decision on whether to pursue securing services from existing carriers, construct new facilities or use both approaches. Small, localized networks may realize significant savings over long terms by owning key assets. Larger, more complex networks frequently cover large geographical areas and entail very intensive network management, maintenance, regulatory and security issues. We believe using existing network facilities, where available, that meet the requirements of the network allows healthcare providers to focus on healthcare services and to ensure network costs are fully predictable. While some assets such as fiber have long lifetimes, there are frequent, unpredictable costs associated with fiber cuts, rights of way, fiber reroutes due to highway or utility construction and network electronics refresh requirements that create unknown costs for network owners. Through the use of well designed RFPs we believe healthcare providers can more effectively manage these costs and achieve faster deployment.

We do support longer term agreements (5-7 years minimum) to allow better long term planning. Some carriers are willing to provide turnkey services under long term agreements similar to IRUs (irrefutable rights of use). We encourage the FCC to accommodate these service options.

Benefits of contracting for a managed solution:

1. Provides the network with a maintenance contract which can contain service level agreements regarding up-time and cap escalators.
2. Provides the capability to scale up the network with agreed upon costs;
3. Guarantees that the network provided is of a sufficient quality to maintain the requirements of a 'medical' grade network;
4. Secure professional Network Operations Center services;
5. Commercial Communications Vendors can easily create relationships with other telecommunications providers across a state to install local circuits and reduce the backhaul expenses. Many times these areas are not considered.
6. Allows public and private entities to use the same network. Some states have restrictions on the use of public facilities to serve private entities.

2. Letters of Agency

26. We propose that as part of the initial application phase for infrastructure projects, applicants identify (1) all eligible health care providers on whose behalf funding is being sought, and (2) the lead entity that will be responsible for completing the application process. In addition, as in the Pilot Program, we would require that the application include a Letter of Agency (LOA) from each participating health care provider, confirming that the health care provider has agreed to participate in the applicant's proposed network, and authorizing the lead entity to act as the health care provider's agent for completing the application process. Such letters of agency will serve as confirmation that the identified health care

providers endorse the proposed network, and will also avoid improper duplicate support for health care providers participating in multiple networks. All such letters of agency would be delivered by the applicant as part of the initial application.⁷

The Letter of Agency does not and should not indicate a commitment on behalf of the proposed participant in the network. Until all costs are known, the participant should have the ability to disengage from the project without penalty. However, once the costs are known and adequately communicated to the proposed participant, there should be a formal understanding/agreement written or implied, and the circuits have been installed at the participant's sites, there is a firm commitment to participate for a prescribed amount of time. This should be especially applicable to any state agencies who actively engage in participation of the network.

28. We also propose that in the case of a consortium, the legally and financially responsible entity that owns dedicated facilities funded by the health infrastructure program could be a state organization, public sector (governmental), or not-for profit entity acting as a fiduciary agent for eligible health care providers within such consortium. For example, a state, public (government) or non-profit entity acting as administrative agent for a consortium of eligible health care providers seeking funding for a dedicated network, could also serve as the title owner of the dedicated network. However, we propose that title to the dedicated network would be held exclusively for the benefit of eligible health care providers.⁸ We seek comment on the above proposals.

Networks developed and deployed under the Rural Health Care Support Mechanism should be incorporated as a 501(c)(3) organization for the reasons stated in the documents of incorporation. A 501(c)(3), as a non-profit organization can obtain grants from agencies such as the National Institutes of Health, the National Science Foundation, and a variety of other governmental agencies or non-profit organizations. The networks can receive monetary gifts and in-kind gifts of services and support as well as become qualified for tax exemption. The 501(c)(3) organization also requires financial audits, formal membership and governance structures, and a Board of Directors and related technical and executive boards as well as Boards of Advisors. These requirements also present an opportunity for evaluation of the organizational effectiveness and financial security of the network. It also helps prevent fraud and discourages misuse of resources.

We do not agree that state/federal organizations should be the legally and financially responsible organizations if non-government entities will also join the network. The entanglements of having a state or federal agency effectively provide IT and telecom services to for-profit and private sector entities are numerous and may prohibit the full utilization of healthcare IT networks as envisioned by this NPRM. It will be very wasteful and inefficient to create separate networks for public and private healthcare providers.

3. Funding Requests and Budgets

32. *Budget.* We propose that together with the funding request, applicants submit a detailed budget that identifies all costs related to the proposed project.⁹ The budget should be reasonable, and should be based

⁷ See Appendix A, 47 C.F.R. § 54.652.

⁸ See *infra* paras. 55 - 58 (Ownership, IRU, and Capital Lease Requirements). Entities could show they meet this requirement by providing an opinion or other documentation prepared by legal counsel.

⁹ See Appendix A, 47 C.F.R. § 54.653(b)(1). In comparison, Pilot Program participants are required to submit budgets on line-item network costs worksheets that accompany FCC Forms 465 and 466-A. See *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20399, para. 76.

on pricing information available to the applicant. All material assumptions used in preparing the budget should be noted and discussed in narrative form. The budget should separately identify the following (each subject to the limitations identified in this NPRM): (1) eligible non-recurring costs; (2) eligible administrative expenses; (3) eligible network design costs; (4) eligible maintenance costs; (5) eligible NLR or Internet2 membership fees; and (6) all costs that are necessary for completion of the project, but that are not eligible for support under the health infrastructure program. If a budget line item contains both eligible and ineligible components, costs should be allocated to the extent that a clear delineation can be made between the eligible and ineligible components.¹⁰

A required detailed budget is reasonable, but may not be practical. If the project is to be built based on a fair bid basis, it will difficult to solicit the assistance of a vendor, vendors, to help identify the above components for a network and then expect a fair-bid process. The RFP solicits, based on specific needs and must have components, proposals which will most efficiently and effectively design/build/implement a broadband network. In many cases, the exact costs to build such as network is not know for many rural areas. Aside for the network backbone and routing equipment, the local circuit installation is the most expensive and difficult to obtain. Detailed accurate costs may not be available at the time of the submission for the grant. Some latitude should be built into this component as it is on many other grants for scientific purposed.

33. Requiring applicants to prepare and submit a budget would ensure that the applicant has given adequate consideration to the project requirements, has undertaken a preliminary analysis of potential costs, and has identified the amount of funds that they will be required to contribute to the overall project. We seek comment on whether the Commission should require applicants to include any additional information in their preliminary budget.

The applicant should think past the actual network and to the applications the network will support. The budget development should contain a reasonable modicum of thought regarding HITECH applications, network affiliations with trusts and other organizations needed to satisfy HIPAA demands as well as the necessity to provide network connected and managed bridging resources for video applications which are essential in telemedicine and Telehealth.

34. We propose that USAC review all project budgets for compliance with program rules.¹¹ USAC could assist prospective applicants with tools that provide benchmark cost estimates for certain items common to all infrastructure projects. We propose allowing budgets submitted by program applicants and program participants to be made available publicly so that other prospective applicants may use such information as a basis for preparing their own budgets.¹² We seek comment on the above proposals.

This section will need input from potential vendors. There are proprietary systems, equipment, or processes which the vendor may or may not be able to disclose these systems and their related costs.

¹⁰ See Appendix A, 47 C.F.R. § 54.653(b)(2); cf. 47 C.F.R. § 54.504(g) (describing mixed eligibility services in the E-Rate program context); see also *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20399, para. 76.

¹¹ See Appendix A, 47 C.F.R. § 54.653(b).

¹² The Commission and USAC may post this information on their respective websites for prospective applicants to review.

38. Because the primary focus of the program should be to fund infrastructure and not project administration, we propose three limitations on administrative expenses. First, support for such expenses will be limited to 36 months, commencing with the month in which a participant has been notified that its project is eligible for funding. This period should be sufficient for completing the majority of program requirements, and support should not be provided beyond this period. Second, we propose that the rate of support will not exceed \$100,000 per year. This amount should be sufficient for one full-time employee (or the equivalent) dedicated to project administration. Participants would be required to submit certifications and maintain records confirming the number of hours provided by one or more employees for tasks related to the health infrastructure program project, and that the administrative expense for which support is sought is not more than the reasonable costs for the amount of time such employee(s) spent on the project. Third, we propose that the aggregate amount of support a project may receive for administrative expenses shall not exceed ten percent of the total budget for the project. We act conservatively in proposing a ten percent cap, which is similar to funding limits on administrative expenses used in some Federal grant programs.¹³ We seek comment on this proposal to provide limited support for administrative expenses.

We would whole heartedly support this proposal. The time required to collect the needed information for the forms, eligibility statements, letters of authority and other administrative requirements is considerable and time consuming. PSPN required 15 months of basically full time involvement of a senior staff person who could provide the needed decision making and had the appropriate fiduciary responsibilities. To off set this by 85% or up to \$100,000 per year will take a tremendous financial burden off those developing the network.

40. *National LambdaRail and Internet2.* We propose that participants may receive support for not more than 85 percent of the membership fees for connecting their networks to the dedicated nationwide backbones, Internet2 or NLR.¹⁴ As in the Pilot Program, while we allow such connections as an eligible expense, we do not indicate that such connections are mandatory or preferred.¹⁵ Thus, under the health infrastructure program, applicants would be free to propose the construction of state or regional dedicated networks that do not connect to a nationwide backbone. It is reasonable to allow, as an eligible expense, membership fees to connect to NLR and Internet2. As noted in the Pilot Program, both of these backbone providers are non-profit entities that already link a number of institutions such as government research institutions and academic, public and private health care providers that house significant medical expertise.¹⁶ By connecting to either of these two dedicated national backbones, health care providers at the state and local levels could have the opportunity to benefit from advanced applications in continuing education and research.¹⁷ While the membership fees for joining NLR or Internet2 would be an eligible

¹³ See Appendix A, 47 C.F.R. § 54.654(c). See, for example, each of the following federal grant programs that allow administrative expenses as an eligible grant cost, but not in excess of 10% of total grant amount: Ryan White HIV/Aids program administered by HRSA, (<http://hab.hrsa.gov/tools/parta/parta/ptAsec2chap2.htm>) (last visited June 24, 2010); Emergency Shelter Grants, administered by HUD (<http://www.hud.gov/offices/cpd/homeless/programs/esg/>) (last visited June 24, 2010); Household Water Well System Grant, administered by RUS (<http://www.rurdev.usda.gov/rd/nofas/2006/031506hwwgp.html>) (last visited June 24, 2010); and National Emergency Grants administered by US Department of Labor (http://www.doleta.gov/neg/admin_req.cfm) (last visited June 24, 2010).

¹⁴ See Appendix A, 47 C.F.R. § 54.654(e).

¹⁵ See *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order on Reconsideration, 22 FCC Rcd 2555, 2556, para. 2 (2007) (*Pilot Program Reconsideration Order*).

¹⁶ See *id.*, 22 FCC Rcd at 2556-57, para. 5.

¹⁷ See *2006 Pilot Program Order*, 21 FCC Rcd at 11111, para. 2.

cost, we do not propose allowing other recurring costs related to connecting to such backbone networks.¹⁸ We seek comment on this proposal.

The PSPN provides connectivity/membership in Internet2 as part of the service package. This provides an Internet alternative to Commodity Internet which has far more traffic, higher incidences of hacking into presumed secure files and Internet2 is highly reliable. The use of TransitRail to reroute Commodity Internet traffic to Internet2 routers provides a valuable and cost effective service reducing Commodity Internet cost approximately 12% while providing more reliable service. Internet2 should be a required service on any of the Rural Health Care networks.

We agree that membership for Internet2/NLR should be a funded expense. However, connection costs to access these networks can be quite substantial and, in many cases, prohibitive, especially in rural areas. We believe support should be provided for reasonable access costs to these networks.

41. For the Pilot Program, the Commission provided that connections to Internet2 or NLR were not subject to the competitive bidding rules requirement.¹⁹ For the health infrastructure program, we propose that participants may either pre-select to connect with either Internet2 or NLR, and seek funding for such connection, or may (at their discretion) seek competitive bids from NLR and Internet2 through the normal competitive bidding process.²⁰ Allowing a participant to pre-select NLR on Internet2 should provide the participant with an opportunity to more fully develop the specific elements of its infrastructure proposal, particularly where only a specific non-profit nationwide backbone provider will fulfill the participant's network plan or meet its need to access a particular institution that is currently connected to only one nationwide network.²¹ If Internet2 or NLR are pre-selected by a participant, the costs of connection to such nationwide backbone must be reasonable. We invite comment on our proposal to exempt connections to Internet2 and NLR from the competitive bidding rules in the new health infrastructure program. Regardless of whether they choose to pre-select NLR or Internet2, participants in the health infrastructure program will be subject to the Commission's audit authority. We emphasize that we retain the discretion to evaluate the activities of participants and determine on a case-by-case basis whether waste, fraud, or abuse has occurred and whether corrective action is necessary.

We highly recommend that at the least Internet2 should be exempt from the competitive bidding rules. We also recommend that Internet2 become a standard, or at the least a default, route to HITECH (HIT and HIE) sites via such Federated Trusts as NHIN.

¹⁸ An example of costs that we propose would not be supported by the health infrastructure program are additional fees that Internet2 members may pay to subscribe to Internet2's "Commons" videoconferencing service. This service "allows subscribing members to schedule and hold distributed working groups, classes, meetings, and conferences in support of research and education." Internet2, The Internet2 Commons, <http://commons.internet2.edu/> (last visited June 24, 2010). Support for the recurring costs of obtaining dedicated broadband access services, however, would be available under the proposed health broadband services program.

¹⁹ See *Pilot Program Reconsideration Order*, 22 FCC Rcd at 2557, para. 6.

²⁰ See Appendix A, 47 C.F.R. § 54.654(e)(2). Some commenters propose allowing participants to use backbones other than Internet2 and NLR. See, e.g., AT&T NBP Public Notice #17 Comments at 1; Oregon Health Network NBP Public Notice #17 Comments at 7.

²¹ See *Pilot Program Reconsideration Order*, 22 FCC Rcd at 2557-58, para. 7.

4. Ineligible Costs

1. *Examples of Ineligible Costs.* We propose that, for the health infrastructure program, as in the Pilot Program, ineligible costs are those costs that are not directly associated with network design, construction, or deployment of a dedicated network for eligible health care providers.²² We seek comment on this proposal. Participants would be required to certify that support from the health infrastructure program will not be used to pay for ineligible costs. We propose that, as in the Pilot Program and consistent with the Act, the authorized purposes of the health infrastructure program would include the costs of *access* to advanced telecommunications services.²³ Ineligible costs would include (but not be limited to) the following costs, because the following costs are not directly related to access or to network design, construction or deployment:²⁴

- Personnel costs (including salaries and fringe benefits), except for those costs that qualify as administrative expenses, subject to the limitations set forth in paragraphs 37 and 38 of this NPRM.
- Travel costs, except for travel costs that are reasonable and necessary for network design or deployment and that are specifically identified and justified as part of a competitive bid for a construction project.
- Legal costs.
 - To effect a realistic Sustainability Plan, the networks will need to become incorporated, preferably into a 501(c)(3) organization which requires legal assistance for the creation of both the Non-Profit organization and any Tax Exemption to which the network is entitled. As with administrative costs, these can be a burden to a new corporation and should be included, within reasonable limits, as an eligible expense. Without the 501(c)(3) designation, the networks cannot receive grants or contracts from NIH or NSF and cannot receive gifts or donations. In the case of such networks, there are equipment grants, clinical grants, research grants and a variety of other funding mechanisms which will both benefit the development, use and sustainability of the network and require the network, as a recipient, to have non-profit status for granting agencies and organizations to make awards.
- Training, except for basic training or instruction directly related to and required for broadband network installation and associated network operations. For example, costs for end-user training, e.g., training of health care provider personnel in the use of telemedicine applications, are ineligible.
- Program administration or technical coordination, except for those costs that qualify as administrative expenses, subject to the limitations set forth in paragraphs 37 and 38 of this NPRM.

²² See Appendix A, 47 C.F.R. § 54.655; see *2007 Pilot Program Selection Order*, 22 FCC Rcd. at 20398, para. 75.

²³ See 47 U.S.C. § 254(h)(2)(A) (directing the Commission “to enhance, to the extent technically feasible and economically reasonable, *access to* advanced telecommunications and information services for all public and non-profit . . . health care providers . . .”) (emphasis added); see also *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20397, para. 74 n.239.

²⁴ See Appendix A, 47 C.F.R. § 54.655(b).

- Inside wiring or networking equipment (e.g., video/Web conferencing equipment and wireless user devices) on health care provider premises except for equipment that terminates a carrier's or other provider's transmission facility and any router/switch that is directly connected to either the facility or the terminating equipment.
 - It would be helpful if the FCC had partnerships or liaison with other federal agencies to facilitate the networks in identifying other federal granting agencies which provide funding for the in-point devices needed to use the network, specifically equipment and software for web based and full motion videoconferencing/telemedicine/Telehealth applications. This equipment is often prohibitively expensive for small hospitals, FQHCs, RHCs, and Primary Care Providers.
- Computers, including servers, and related hardware (e.g., printers, scanners, laptops), unless used exclusively for network management.
 - Consider expanding the use of end-point network devices such as telemedicine carts and computers used exclusively for HIEx or telemedicine applications.
- Helpdesk equipment and related software, or services.
- Software, unless used for network management, maintenance, or other network operations; software development (excluding development of software that supports network management, maintenance, and other network operations); Web server hosting; and Website portal development.
 - See above
- Telemedicine applications and software.
 - See above
- Clinical or medical equipment.
- Electronic records management and expenses.
- Connections to ineligible network participants or sites (e.g., for-profit health care providers).
 - Currently many not-for-profit hospitals are being bought by for-profit chains in rural areas across the country. These are often the only hospitals in their county and also have the only dedicated Emergency Department for the county. In addition, some Rural Health Centers are For-Profit and Primary Care Physicians practices are also for profit. These organizations have legitimate need for access to healthcare networks and in many situations cannot afford the 'fair share' cost of the services. The Federal mandates to use EMRs and EHRs will directly affect these entities along with the state and non-profit entities on the network. Consider allowing for-profit health care providers to participate in the subsidized fee structure as an extension of the network to the patient populations in medically underserved or un-served areas. These entities may be in urban as well as rural areas.
- Costs related to any share of a project that is not allocable to the dedicated healthcare network.

- Administration and marketing costs (e.g., administrative costs; supplies and materials; marketing studies, marketing activities, or outreach efforts; evaluation and feedback studies), except for those costs that qualify as eligible administrative expenses, subject to the limitations set forth in paragraphs 37 and 38 of this NPRM.
- Continuous power source.

C. Provisions Applicable After Initial Application

1. Fifteen Percent Contribution Requirement.

44. *Minimum Participant Contribution.* We propose that as one of the conditions to receiving any funding commitments from USAC, participants submit certification of the availability of funds, from eligible sources, for at least 15 percent of all eligible costs.²⁵ We seek comment on this proposal. The Pilot Program similarly required a 15 percent minimum contribution requirement for all eligible costs. As recognized by the National Broadband Plan, the participant contribution requirement aligns incentives and helps ensure that the health care provider values the broadband services being deployed, and makes financially prudent decisions regarding the project.²⁶ Ensuring that each participant has a financial stake in the project is an important part of the implementation of infrastructure projects, as well as critical to maintaining overall accountability for prudent use of finite universal service funds. We therefore propose that the health infrastructure program would pay not more than 85 percent of eligible project costs, and participants would be required to pay the remaining 15 percent of such eligible projects costs. In addition, participants would be required to pay all costs that are related to the project but that do not qualify as eligible project costs.

In many states, counties, or municipalities, as well as the colleges, universities, and organizations submitting proposals to participate in the Rural Health Care programs, there is no access to matching funds. Most of the projects are expensive and run into millions of dollars to be executed properly. A match of 15-20% as specified exempts many worthy projects. Provisions to exempt the matching funds should be made for entities making proposals for which no funds truly exist. You may also consider the creation of or assistance in identifying a matching grant process which can provide the needed matching funds for projects which have proven the efficacy of their proposal as well as their financial situation.

45. We note that the matching funds requirement for the Broadband Technology Opportunities Program (BTOP), established pursuant to the Recovery Act, is generally 20 percent of eligible costs, and that the Broadband Initiatives Program (BIP), also established pursuant to the Recovery Act, will fund 75 percent in grants and 25 percent in loans.²⁷ We have learned from our experience with the Pilot Program that

²⁵ See *id.* 47 C.F.R. § 54.656.

²⁶ National Broadband Plan at 215 (NBP Recommendation 10.7).

²⁷ See *Broadband Initiatives Program/Broadband Technology Opportunities Program, Notice of Funds Availability and Solicitation of Applications*, 75 Fed. Reg. 3792, 3799, 3822 (Jan. 22, 2010). The Broadband Technology Opportunities Program (BTOP), established pursuant to the Recovery Act, provides grants for deploying broadband infrastructure in unserved and underserved areas of the United States. See Broadband USA, BTOP, <http://www2.ntia.doc.gov/about> (last visited June 24, 2010). The Broadband Initiatives Program (BIP), also established pursuant to the Recovery Act, provides loans, grants, and loan/grant combinations to facilitate broadband deployment in rural areas. See Broadband USA, BIP, <http://www.broadbandusa.gov/BIPportal/index.htm> (last visited June 24, 2010).

some applicants have difficulty even meeting a 15 percent contribution requirement.²⁸ At the same time, one of the benefits of increasing the contribution requirement to 20 percent or higher would be that more funds would be available under the program to fund additional projects. We invite comment on whether the Commission should consider a higher level of participant contribution for health infrastructure projects. Commenters should identify whether, in light of higher levels of participant contributions in the BTOP and BIP programs, the contribution requirement for the health infrastructure program should be more than 15 percent to ensure better efficiencies and greater level of “at risk” commitment by participants to their projects.

The poor participation in the RHC Regular Program has dual root causes. First, the requirements for application and implementation are restrictive and onerous. In many situations, the nature of the program requirements prohibit the accomplishment of the proposed project rather than facilitate it. Secondly, matching funds do not exist. Increasing the match may increase the amount of funds that are available. However, applications will drop due to the burden of finding matching funds of 15 or 20% which are eligible, if they can be found in the first place. Consider the NIH. Grants are provided not only without matching funds requirements, but they also allow Indirect Cost allocations to the award to cover allowable and eligible administrative overhead. While we do not propose that Indirect Costs are considered, waiving the matching funds will increase the number of viable applications for rural, underserved, un-served or poor areas/states.

46. Evidence of Viable Source for 15 Percent Contribution. We propose that, within 90 days after being notified of project selection, participants demonstrate that they have a reasonable and viable source for the minimum 15 percent contribution.²⁹ Many projects in the Pilot Program indicated deployment delays due to many factors, including difficulty in obtaining the minimum 15 percent contribution.³⁰ This, among other factors, resulted in the Bureau extending (by one year) the deadline for participants in the Pilot Program to select vendors and request funding commitments from USAC.³¹ To ensure that projects are completed in a timely manner, it is important for participants in the health infrastructure program to meet a date certain by which they have secured the minimum 15 percent contribution for eligible project costs. Doing so will ensure that program funds are not indefinitely allocated to projects that cannot proceed to completion due to lack of adequate financial contribution from the participant. We therefore propose that after a participant has been notified that, based on its initial application, its project is eligible for funding, the participant have a period of 90 days to submit letters of assurances confirming funds from eligible sources to meet the 15 percent minimum contribution requirement. We seek comment on this proposal.

As a Pilot program participant, we found that the delays and excessive time required to meet the FCC/USAC rules for establishing site eligibility, drafting and posting the RFP, awarding the contract and submitting the NCW, approval and issuing the FCL often exceeded the time the matching funds were available. Our matching funds were eligible state funds. However, the time required to accomplish the operational requirements of the project with the FCC/USAC saw us move from one Fiscal Year to another. In these times of fiscal problems and downturns in state revenues, un-encumbered or un-used

²⁸ For example, commenters responding to the *NBP Public Notice #17* noted that it is difficult for rural health care providers to secure funds to invest in broadband infrastructure, given the competing demands for limited resources in rural areas. See, e.g., Northwest Healthcare NBP Public Notice #17 Comments at 2; St. John’s Hospital NBP Public Notice #17 Comments at 2; Glacier Community, NBP Public Notice #17 Comments at 2.

²⁹ See Appendix A, 47 C.F.R. § 54.656(b).

³⁰ *2010 Pilot Program Extension Order*, 25 FCC Rcd at 1423.

³¹ *Id.*

funds are taken from budgets and returned to the state's general funds. In essence, the nature of the RHC project almost insures that matching state funds may be come un-available. These funds are difficult to initially justify and procure.

47. Eligible Sources. We propose placing limitations on the eligible sources for matching funds. Selected participants would be required to identify with specificity their source(s) of funding for the minimum 15 percent contribution of eligible network costs.³² Only funds from an eligible source may apply towards meeting this requirement. As in the Pilot Program, eligible sources would be limited to (1) eligible health care providers; (2) state grants, funding, or appropriations; (3) federal funding, grants, loans, or appropriations (but not other universal service funding); and (4) other grant funding, including private grants. Participants who do not demonstrate that their 15 percent contribution comes from an eligible source or whose minimum 15 percent contribution is derived from an ineligible source would be denied funding by USAC. Ineligible sources would include (1) in-kind or implied contributions; (2) a local exchange carrier (LEC) or other telecom carrier, utility, contractor, consultant, or other service provider; and (3) for-profit participants.³³ Moreover, selected participants may not obtain any portion of their 15 percent contribution from any universal service support program. These limitations on eligible sources would safeguard against program manipulation, and would prevent conflicts of interest or influence from vendors and for-profit entities that may lead to waste, fraud, and abuse. We therefore propose that these limitations, which were applied to the Pilot Program, be applied to the health infrastructure program. We seek comment on the proposed list of eligible sources.

It is recognized that funding should not come from sources where a conflict of interest will be created and that restrictions are needed. However, if the restrictions are so onerous that they prohibit potential participation by worthy projects, such restrictions are counter productive. Too many restrictions will result in the same outcome as the current RHC Regular program. No one will participate.

3. DETAILED PROJECT DESCRIPTION

53. Health IT Purposes. We propose requiring that, as part of the project description, participants specify how the dedicated broadband network will be used by eligible health care providers for health IT to improve or provide health care delivery.³⁴ As defined in the National Broadband Plan, "health IT" refers to information-driven health practices and the technologies that enable them.³⁵ Health IT includes billing and scheduling systems, e-care, electronic health records (EHRs) and telehealth and telemedicine.³⁶ In adopting the Pilot Program, the Commission recognized the benefits of telehealth and telemedicine.³⁷ We seek comment on this proposal. Consistent with the National Broadband Plan's recommendation to adopt

³² See Appendix A, 47 C.F.R. § 54.656(c)-(d).

³³ See *id.* § 54.656(d).

³⁴ See Appendix A, 47 C.F.R. §§ 54.602(e), 54.658(d).

³⁵ National Broadband Plan at 200.

³⁶ "E-care" refers to the electronic exchange of information – data, images and video—to aid in the practice of medicine and advance analytics. *Id.*

³⁷ See *2006 Pilot Program Order*, 21 FCC Rcd at 11111, para. 1 (noting that the pilot program would fund networks designed to bring the benefits of innovative telehealth and telemedicine services to those areas of the country where the need for such benefit is most acute). Telemedicine is the provision of medical care from a distance using telecommunications technology. *Id.* Telemedicine includes a broad set of applications using communications technologies to support long-distance clinical care, consumer and professional health-related education, public health, health administration, research and electronic health records. *Id.*

outcome-based performance goals for the Rural Health Care program, we seek comment below on how best to monitor how participants are utilizing dedicated broadband networks to support these health IT purposes.

The FCC should consider a “Broadband Meaningful Use (BMU)” Stimulus Program aimed at all Providers which would include physicians and for-profit hospitals that are not covered in the existing RHC programs. The BMU would be tailored after the ONC’s EMR meaningful use program that has gained significant traction across the country. Incentivizing MD’s to adopt broadband technology and dedicated healthcare networks will greatly facilitated exchange of patient data, telemedicine and telehealth activities.

54. Emergency Response Connectivity. We seek comment on whether every project should be required to include ways in which the proposed network will be used in emergency response and meet disaster preparedness requirements.³⁸ We also seek comment on whether every project should be required to include ways in which the proposed network will provide effective and secure connectivity, and peering with other networks in order to address global public health and border issues.³⁹

It should be required that any network developed for health care applications under this program include emergency response, health department, disaster preparedness and homeland security requirements. However, many state governments will require some form of regulation of the communications traffic over these networks.

5. Sustainability Reporting Requirement

65. Consistent with the recommendations of the National Broadband Plan, we propose requiring that, prior to receiving a funding commitment letter from USAC, participants submit a sustainability report demonstrating that the project is sustainable.⁴⁰ Although participants would be free to include additional information to demonstrate a project’s sustainability, we propose that a sustainability plan would at a minimum address the following points:⁴¹

- **Ownership Structure.** Explain who will own each material element of the network, and arrangements made to ensure continued use of such elements by the network members for the duration of the sustainability period.

Incorporation of the network into a 501(c)(3) builds in auditing and governance structures which will identify stakeholders, leadership, membership requirements/recruitment, fees and recurring costs, standards,

³⁸ See Internet2 June 25, 2010 *Ex Parte* Letter, at 3 (“In disaster situations, it is often the local institution that is on the front line of the response.”).

³⁹ See *id.* at 4 (“Effective and secure International connectivity and peering with other international networks are needed as the country addresses global public health and border health issues. Examples include increasing international public health concerns, such as tuberculosis, HIV/AIDS, pandemic influenza, chem-bio terrorism, that require improved surveillance, situational awareness, consequence management, sharing data and information that would include rural sites, larger centers and national or international agencies.”).

⁴⁰ See Appendix A, 47 C.F.R. § 54.661; National Broadband Plan at 215 (NBP Recommendation 10.7).

⁴¹ Similar sustainability factors were recommended for use in the Pilot Program, as set forth in the Pilot Program FAQs, available at <http://www.fcc.gov/cgb/rural/rhcp.html#faq24> (last visited June 24, 2010).

- Management. Describe the management structure of the network for the duration of the sustainability period, and how management costs will be funded.

Incorporation of the network into a 501(c)(3) builds in auditing and governance structures which will identify stakeholders, leadership, membership requirements/recruitment, fees and recurring costs, standards, and the ability to procure grants and contracts as well as gifts and donations. Incorporation is a method of supporting the sustainability of the project once the FCC funding is expended. Board of Directors, Executive Boards and Technology committees are essential for maintaining the standards and security of a medical network. and the ability to procure grants and contracts as well as gifts and donations. Incorporation is a method of supporting the sustainability of the project once the FCC funding is expended.

6. Shared Use

74. In the event we adopt an incremental cost approach, should we make a bright line distinction so if ineligible users take more than a set percentage of the network's capacity, then they would be required to pay a larger share based on fully-distributed costs (rather than merely incremental cost)?

Depending upon the definitions of ineligibility, this may prohibit legitimate use of the network in rural, or urban underserved/un-served areas. Currently, by definition Primary Care Physicians and clinics in both rural and urban underserved areas are not eligible. If they are required to pay their Fair Share, it should be a fair cost and not used to underwrite the participating entities deemed eligible by the program. There are many PCPs and RHCs in areas which do not fit the restrictive definitions and requirements of the current RHC program which are in legitimate need of the support and network access. Actually, a mechanism should be developed to make it attractive for such 'ineligible' entities to participate at affordable rates.

76. *Protecting Against Fraud, Waste and Abuse.* We seek comment on what limitations on additional capacity for community use are necessary to protect the integrity of dedicated health care networks, and to help ensure that eligible health care providers receive the maximum benefit from infrastructure funded by universal service funds. We seek comment on what restrictions or measures we should adopt to prevent fraud, waste and abuse as a result of projects that involve dedicated health care networks and additional capacity for use by entities that are not eligible health care providers under our rules. For instance, if the Commission allows excess capacity to be shared by other community uses at incremental cost, should it require that:

The projects should be prohibited from reselling excess bandwidth. The networks are for healthcare, homeland security, emergency preparedness, health department and other secured uses. Selling excess capacity introduces not only the potential for fraud and abuse, but the co-mingling of un-necessary commercial traffic.

- Network members must have a written agreement or organizational document that specifies the members' respective rights and obligations, including access and maintenance, and reasonable (i.e., arm's length) allocation of recurring and non-recurring costs.

All projects should create a Business Associates Agreement to insure that there is an understanding of the necessity of security and liability involved with security breaches of Protected Health Information and other sensitive information.

78. *Additional Capacity for Community Use.* In addition to the proposed rules above (regarding excess capacity for health care purposes), we seek comment on whether we should encourage, permit, or restrict

the following categories of joint projects that include additional capacity for use by the community (not for health care purposes):⁴²

- Additional capacity for use by schools and libraries;

No, E-Rate should take care of this.

- Additional capacity for use by governmental entities (state and local); and

Yes, with conditions. State and Local governments tend to require more control and fees of such networks and may inhibit the use to a point of ineffectiveness. There must be safeguards in place to insure that the RHC networks continue to be dedicated to Health Care, emergency preparedness, community health and homeland security.

- Additional capacity for use by other entities in the community, such as local non-profits, community or civic organizations, low-income residents, local businesses, anchor institutions and other residents.

Definitely not. These networks are needed for restricted medical and health related uses. Bandwidth can be easily usurped by excessive use of RSS feeds for purely commercial use and prohibit the applications for which the networks are designed and built. If such networks are needed, additional plans should be in place by the FCC to extend commercial applications networks into these areas.

79. Priority Preferences for Projects that Include Additional Capacity for Community Use. For each of the above types of additional capacity for community use listed in paragraph 78, we seek comments on whether projects funded by the health infrastructure program should include, restrict, or allow these types of joint or shared projects. We also invite comment on priority preference and other issues. For example:

- If we cap the number of projects per year, or if the number of projects per year under the health infrastructure program exceeds the proposed \$100 million funding cap,⁴³ should we give special prioritization treatment to projects that plan to allow use of excess capacity by schools and libraries that are otherwise eligible for universal service funding?

No, definitely not. There is a paucity of funds available to support medically and health care related activities in rural and underserved/un-served areas now. Giving priority treatment to projects that deviate from the primary focus of the project will weaken the effectiveness of the program. If networks are needed for schools, libraries and other USAC eligible entities, and they are, there should be parallel programs for this purpose. Co-mingling the two will be counterproductive.

⁴² See, e.g., Oregon Health Network NBP Public Notice #17 Comments at 10 (noting that broadband connectivity can be achieved nationwide through an “anchor tenant” model that includes institutions such as schools, hospitals, and government); Internet2 June 25, 2010 *Ex Parte* Letter, at 3 (“Health care is critical to all areas of the US but it is not the only use of broadband resources. In fact, there are regions of the country where broadband is being analyzed as a community resource for economic development or other rationales. The aggregation of broadband demand, including health care, must be viewed positively and encouraged.”).

⁴³ See *infra* paras. 128- 134 regarding prioritization rules; *supra* para. 31, seeking comment on a cap for the number of projects per year under the health infrastructure program.

- Should we give priority to projects that allow use of excess capacity by state or local government (including government offices, police, fire departments and Emergency Medical Services)?

Yes. However, access by state or local government should be limited to police, fire, EMS, homeland security, disability services, Health Departments and prisons. While the PSPN had difficulty overcoming some of the roadblocks dealing with the state IT departments and providing the services to a state agency, such collaborations are highly desirable. State departments of Homeland Security, Health and Environmental Control, Mental Health, Prisons, Law Enforcement and others are very desirable and needed partners. South Carolina does not have a 'back-up' network in the event of natural disasters (hurricanes, tornadoes, etc.) and certainly not cyber terrorism. The PSPN would make an excellent partner, if cooperative arrangements can be reached.

- Should other community use be allowed or restricted?

Not allowed.

8. Quarterly Reporting Requirements

84. We propose requiring that health infrastructure program participants submit quarterly reports that provide information on the following: (1) attaining project milestones, (2) status of obtaining the 15 percent minimum match, (3) status of the competitive bidding process, (4) details on how the supported network has complied with HHS health IT guidelines or requirements, such as meaningful use, if applicable; and (6) performance measures (as described in more detail in Section IX of this NPRM).⁴⁴ We seek comment on this proposal, and on whether such reports should only be required annually or semi-annually. Such information could inform the Commission's understanding of cost-effectiveness and efficacy of the different state and regional networks funded by the program and guide future decision-making. This information should also enable the Commission to ensure that universal service funds are being used in a manner consistent with section 254 of the Act and the Commission's rules and orders.⁴⁵ In particular, collection of this information is critical to the goal of preventing waste, fraud, and abuse by ensuring that funding is flowing to its intended beneficiaries.⁴⁶ Participants should also note that submission of a quarterly report is not a substitute for seeking consent for any material modification to the original application.

The quarterly report is an excellent procedure for reporting accomplishments. However, a common format should be adopted.

9. Competitive Bidding

85. We propose that all projects funded by the health infrastructure program be subject to fair and open competitive bidding.⁴⁷ Currently, health care providers seeking support under the Rural Health Care Support Mechanism post a request for services on USAC's website for a period of at least 28 days, using

⁴⁴ See *id.* § 54.663.

⁴⁵ See 47 U.S.C. § 254; 47 C.F.R. Part 54, Subpart G.

⁴⁶ Also, we note that selected participants will be subject to audit oversight as discussed *infra* para. 139.

⁴⁷ See Appendix A, 47 C.F.R. § 54.603(a).

FCC Form 465, which serves as a method for USAC and potential vendors to be aware of requests for services.⁴⁸ Because of the complexity of infrastructure projects, participants in the health infrastructure program should be explicitly required to prepare a detailed request for proposals (RFP) that provides sufficient information to define the scope of the project, and to distribute the RFP in a method likely to garner attention from interested vendors.⁴⁹ For example, participants could (1) post a notice of the RFP in trade journals or newspaper advertisements, (2) send the RFP to known or potential service providers, (3) include the RFP on the health care provider's web page or other Internet sites, or (4) follow other customary and reasonable solicitation practices used in competitive bidding. Adding this mandatory RFP preparation and distribution requirement could increase the quality and quantity of bids received by health care providers for their network projects, and will therefore result in a more efficient use of funding under the health infrastructure program. We seek comment on whether participants also should be required to post an FCC Form 465 and note on that form that they have issued a detailed RFP. If participants using an RFP are not required to use an FCC Form 465, then the certifications that are contained in the Form 465 would be included in a substitute form.

The RFP itself is a request for vendors to provide the solicitors with their proposals to connect specific areas and entities within those areas. The Form 465 may be too detailed for this purpose at this time in the solicitation process. Once the RFP is completed and the vendor is identified, the contract will cover all the areas of the 465. Posting a Form 465 prior to or with the RFP seems to be excessive and limiting to those making proposals.

86. We recognize that in certain smaller projects, or in projects that are subject to mandatory, state or local procurement rules, our proposed RFP preparation and distribution requirements may not be practical or cost-effective. Accordingly, our proposed RFP requirements would not be applicable to infrastructure projects of \$100,000 or less or projects that are subject to mandatory state or local procurement rules.⁵⁰ However, such projects would still be required to complete a request for services on an FCC Form 465 and post this request on USAC's webpage for a period of at least 28 days before selecting a vendor. We propose that health care providers be required to certify that each service or facility provider selected for an infrastructure project supported by the health infrastructure program is, to the best of the health care provider's knowledge, the most cost-effective service or facility provider available, as defined in our rules.⁵¹ We seek comment on the above proposals.

The FCC/USAC rules are fairly consistent with state procurement rules. The FCC may consider allowing the posting of the RFP on both the state and local as well as the FCC sites for the 28 day period. The FCC process should be followed, but should also accommodate any specific state or local requirement as long as it does not compromise the fair bidding process. In addition, there will be projects in the future to connect multiple sites to the networks. PSPN is currently working with the FQHCs in aggregate across the entire state to connect them to the network. We were advised to have on person coordinate the submission of the eligibility date in aggregate on one Form 465. This will considerably exceed the proposed \$100,000 maximum. The FCC might consider waiving the RFP requirement for aggregate application to an RHC network such as the PSPN. The contractor was selected and approved through

⁴⁸ 47 C.F.R. § 54.603(a); *see* Appendix A, 47 C.F.R. § 54.603(b).

⁴⁹ *See* Appendix A, 47 C.F.R. § 54.603(b).

⁵⁰ *See id.* § 54.603(b). We note that in federal procurements, a less stringent simplified acquisition procedure is used for contracts of \$100,000 or less. *See* 41 U.S.C. § 403(11).

⁵¹ *See Universal Service First Report and Order*, 12 FCC Rcd at 9134, para. 687; 47 C.F.R. § 54.615(c)(7); Appendix A, 47 C.F.R. § 54.603(c)(4).

competitive bidding and evaluation by the project and USAC. The contractor is also evergreen. An additional RFP may be excessive and unnecessary.

93. Eligible Access and Transport Services. Pursuant to section 254(h)(2)(A), and consistent with the recommendations made in the National Broadband Plan, we propose to replace the existing internet access program with a new "health broadband services program," which will subsidize 50 percent of an eligible rural health care provider's recurring monthly costs for any advanced telecommunications and information services that provide point-to-point broadband connectivity, including Dedicated Internet Access.⁵² We seek comment on this proposal. We note that section 254(h)(2)(A) is not limited to health care providers in rural areas. We seek comment on whether an appropriate first step for expanding funding for broadband services should be to focus on rural areas, given the particular challenges that rural communities often face in obtaining access to health care. We also invite comment on whether this proposal implicates section 254(h)(1)(A),⁵³ and if so, how we would implement the proposed health broadband services program in light of section 254(h)(1)(A). For instance, should we require that recipients seeking funding for telecommunications services to make an election as to whether they wish to receive support under the telecommunications program or under the new proposed health broadband services program?

The subsidy of 50% is not sufficient for rural area health care entities. Pure economics will eliminate many of the rural, underserved, and un-served entities from participating. The Commission should consider increasing the subsidy to between 75% and 85% for all telecommunications services, Internet, Broadband, and Dedicated Internet Access. Unless the subsidy is substantially higher than the proposed 50%, the program will not succeed in rural areas. In addition, many counties that are currently designated as Urban have pockets of under served and un-served areas where such service is not available or economic conditions are so severe that the service is beyond their means. It is also recommended that the Commission consider a new system for classifying eligible entities. Support for commodity Internet access should be the same as other supported services to reduce administrative costs and allow rural entities to practically use the network for its Internet access as well.

96. We propose that the health broadband services program provide support to eligible rural health care providers for the recurring costs of access to advanced telecommunications and information services that enable rural health care providers to post their own data, interact with stored data, generate new data, or communicate over private dedicated networks or the public Internet for the provision of health IT.⁵⁴

The PSPN is currently engineered to provide it's members with private broadband, Commodity Internet and Internet2. The ultimate goal is to push this service out to Primary Care Providers and other physicians across the state. PHI and other sensitive data can be transmitted to CMS and other agencies via NHIN, a federated trust. Access to this is essential for all healthcare entities in the future. Also providing private broadband which can support VPNS and QOS is also essential not only for data transmission but telemedicine applications. Significant improvements in the use of secured Internet sites now provides health care providers with the ability to use secured web sites and sophisticated conferencing tools to securely upload Private health Information, patient records, patient video, diagnostics and use them to conduct real-time, live health care conferences across the state and beyond.

⁵² See Appendix A, 47 C.F.R. § 54.631(a).

⁵³ See 47 U.S.C. § 254(h)(1)(A) (authorizing universal service support for the difference, if any, between the rates for telecommunications services provided to health care providers for rural areas in a State and the rates for similar services provided to other customers in corporate rural areas in that State).

⁵⁴ See Appendix A, 47 C.F.R. §§ 54.602(e); 54.631(c).

There should be no requirement that all PHI is transmitted over private broadband. But there should be a clear requirement that all PHI and other diagnostic information is transmitted in accordance with the HIPAA rules.

97. We seek comment on whether we should define a minimum level of broadband capability for purposes of providing support under the new health broadband services program.⁵⁵ The National Broadband Plan suggested that 4 Mbps downstream is the minimum necessary for a solo practitioner to support the deployment of health IT applications today and in the near future, whereas the recommended bandwidth for other health care providers is 10 Mbps for small clinics and health care providers with 2 to 4 physicians, 25 Mbps for larger clinics and health care providers with 5 or more physicians, 100 Mbps for hospitals and 1,000 Mbps for large medical centers.⁵⁶ Would 4 Mbps be an appropriate minimum for purposes of the new health broadband services program, or should we require different minimum speeds depending on the type of health care provider? Four (4) Mbps could be a sufficient minimum requirement since the health broadband services program would be used to fund broadband services without funding additional infrastructure. In contrast, for the health infrastructure program, given the use of funding specifically for broadband deployment, the minimum broadband speed should be higher.⁵⁷ We also seek comment on minimum levels of reliability, including physical redundancy, to support health IT services and what can be done to encourage reliability.⁵⁸ We also seek comment on the minimum quality of service standards necessary to meet health IT needs. We seek comment on whether the health broadband services program should contain a minimum quality of service requirement.

The networks should offer a minimum total of at least 10MB of bandwidth which contains both broadband and Internet both of which can be scaled to meet the needs of the user. A minimum of 4MB of broadband, better if 5MB, can be used to support two concurrent full motion video telemedicine events. Additionally, a minimum of 3 to 4 MB of Commodity Internet is needed to successfully move medical data quickly enough to meet clinical needs. Access to Internet2 provides the HCPs with an alternate and/or additional path for transmissions. All local circuits installed should have the capacity to be scaled up, in increments, to 1GB.

All connections, regardless of bandwidth, should be symmetrical to efficiently accommodate HD video and imaging transactions. Circuits with differing download vs. upload speeds will create major network problems in terms of management. In addition circuits should not be subject to bandwidth fluctuations resulting from connection/backbone oversubscription or routing obstacles.

102. We recognize that in some situations service providers may deploy new facilities to serve eligible health care entities, and may seek to recover all or part of those costs through non-recurring charges when service is initiated. Consistent with policies adopted in the schools and libraries support mechanism, we propose that applicants may not seek upfront support for non-recurring charges of \$500,000 or more.⁵⁹ If

⁵⁵ See *id.* § 54.631(e); Internet2 June 25, 2010 *Ex Parte* Letter, at 2-3 (bandwidth requirements differ depending on the type of service being provided by the health care site).

⁵⁶ National Broadband Plan at 210, Exhibit 10-C.

⁵⁷ See *supra* para. 20, discussing minimum connectivity speeds for the health infrastructure program.

⁵⁸ See Internet2 June 25, 2010 *Ex Parte* Letter, at 1 (suggesting that funded services should include minimum standards of quality of service, including reliability, bit relay, jitter, packet dropping probability and/or bit error rate).

⁵⁹ See Appendix A, 47 C.F.R. § 54.633(c); *cf.* USAC, Schools and Libraries, Wide Area Network (WAN) Fact Sheet, <http://www.universalservice.org/sl/applicants/step06/wide-area-network-fact-sheet.aspx#5> (last visited June 24, 2010).

non-recurring charges are more than \$500,000, they must be part of a multi-year contract, and must be prorated over a period of at least five years.⁶⁰ We seek comment on these proposals.

The installation of routers, servers and upgrades to Network Operations Centers to facilitate the build-out of new networks can rapidly exceed \$500,000. Mandating a prorated multi-year contract for at least 5 years may prove burdensome to the service providers. Based on the rapid evolution of technology and chronological limits placed on manufacturer support 5 years is a safe maximum time.

106. We note that, on average, health care providers that applied for the urban/rural cost difference for eligible telecommunications services under the existing telecommunications program received funding commitments for a 60 percent discount on their cost of service; a significant number of those funding commitments are for T-1 lines.⁶¹ We do not have sufficient information at this time regarding the comparative costs of higher bandwidth services that increasingly may be used by health care providers in the future as they employ health IT applications for telehealth and e-care, nor do we have information that would enable us to develop an administratively workable affordability benchmark. Given the dearth of available information, a cautious approach could be to adopt a flat discount of 50 percent for monthly recurring costs and evaluate, after some period of time, whether such a flat discount results in increased adoption and utilization of broadband for health care purposes. We seek comment on this proposal, as discussed in this section.

T1 lines are of insufficient bandwidth and excessive costs for the support of full motion telemedicine applications or more than one telemedicine application and or other transmissions. MPLS or MetroE circuits can provide higher levels of connectivity as needed and at lower costs. Even at the lower rates, the broadband is expensive for rural and underserved areas. A 50 % or higher discount will help speed deployment of services to these areas. The current RHC program provides discounts on telecom services based on comparisons of urban rates vs rural rates. USAC posts urban rates on its web site for certain services. Distance sensitive rates are available based on specific guidelines. PSPN participants differ from typical RHC participants for the following reasons: (1). All circuits are Ethernet and capable of providing virtual connections to any other PSPN user in the state. (2). Connections to PSPN are made to the nearest PSPN hub but actual usage configurations may have numerous virtual paths and may go anywhere in the state. Service distances vary by user and can change without a physical change in the circuit. (3). PSPN circuits do not appear to match any services, speeds or urban rates posted on the USAC web site.

Therefore, we request the following from USAC: (a) Allow new, eligible PSPN users seeking funding under the RHC the flexibility to apply for funding as a group, utilizing a single RFP where possible. (b).

⁶⁰ In the *Brooklyn Order*, the Commission determined that where the non-recurring charge for capital investment “vastly exceeds” the monthly recurring charge, recipients may receive discounts on non-recurring charges associated with capital investment made by a service provider in an amount equal to the investment prorated over a term of at least three years. *Request for Review of the Decision of the Universal Service Administrator by Brooklyn Public Library Brooklyn, New York; Federal-State Joint Board on Universal Service; Changes to the Board of Directors of the National Exchange Carrier Association, Inc.*, CC Docket Nos. 96-45, 97-21, Order, 15 FCC Rcd 18598, 18606, para. 20 (2000) (*Brooklyn Order*). In 2003, the Commission sought comment on whether to limit the recovery of upfront charges for capital investments to no more than 25 of a funding request and whether to require amortization of non-recurring charges of more than \$500,000 over at least five years. *Schools and Libraries Universal Service Support Mechanism*, CC Docket No. 02-6, Third Report and Order and Second Further Notice of Proposed Rulemaking, 18 FCC Rcd 26912, 26943, paras. 74-75 (2003).

⁶¹ See Letter from Universal Service Administrative Company, to Marlene H. Dortch, Secretary, Federal Communications Commission, GN Docket Nos. 09-47, 09-51, 09-137, WC Docket No. 02-60 (dated Feb. 23, 2010).

Establish a common discount level for PSPN connections for all eligible users and all bandwidths, regardless of rural location.; and (c). Provide a subsidy of at least 50%, with preference to a higher subsidy, on recurring expenses for broadband connectivity. We believe discount levels need to be at least 75% to enable many rural entities to participate.

108. We also seek input on whether affordability metrics could be incorporated into the flat rate methodology proposed above. Are there factors that could be considered under a flat rate funding mechanism that target health care providers in rural areas that still could not afford broadband access services under the 50 percent funding threshold?

The 50% funding threshold is much too low. Subsidy should be in the 75% - 85% range. Affordability is key to usage. A 25% to 15% responsibility for the health care providers will sufficiently encourage prudent use.

111. We propose to codify this practice as part of the new health broadband services program. If they choose to do so, program participants will be allowed to enter into multi-year contracts for recurring broadband services.⁶² Further, we propose that multi-year contracts that are competitively bid in accordance with the Commission's rules and that are deemed to have evergreen status by USAC do not need to be re-bid each year, for the life of the contract.⁶³ However, consistent with current policy, all health care providers would be required to continue to request support annually by filing an FCC Form 466-A.⁶⁴ Additionally, any changes to the parties' evergreen contract, such as an extension, renewal, or the addition of services, would require the posting of a new FCC Form 465.⁶⁵ Codifying this existing practice would maintain consistency while transitioning from the existing internet access program to the new health broadband services program. Health care providers would also benefit from the opportunity to enter into long-term contracts with service providers, which may offer lower pricing than would be available on an annual basis. Moreover, the administrative obligations would be reduced for those providers who do not file a Form 465 each year.⁶⁶ We seek comment on our proposal.

The current contract under which our Pilot program has operated has a multi year contract with excellent rates. The yearly renewal process is not only cumbersome, but does not encourage best rates. It also prohibits long range planning which is necessary to a good sustainability plan. Three to 5 year plans with provisions for reviewing rates if they change significantly (+/-) is recommended.

112. *Opting into the Health Broadband Services Program.* Under the Pilot Program, we permitted participants to seek support for both the recurring and non-recurring costs associated with the deployment of broadband health care networks and the advanced telecommunications and information services provided over those networks.⁶⁷ When the Pilot Program ends, some participants may wish to transition to the new health broadband services program to subsidize the recurring costs formerly funded by the

⁶² See Appendix A, 47 C.F.R. § 54.641(a).

⁶³ See *id.* § 54.641(b).

⁶⁴ See *id.* § 54.641(c).

⁶⁵ See *id.* § 54.641(b); cf. USAC, Rural Health Care Webpage, Evergreen Contracts, <http://www.usac.org/rhc/health-care-providers/step04/evergreen-contracts.aspx> (last visited June 24, 2010).

⁶⁶ See, e.g., Oregon Health Network NBP Public Notice #17 Comments at 7 (noting that health care providers with multiyear contracts should not have to reapply for support each year, as it can be a financially burdensome process for the health care provider).

⁶⁷ 2007 Pilot Program Selection Order, 22 FCC Rcd at 20397, para. 74.

Pilot Program. We seek comment on whether Pilot Program participants whose original request for competitive bids included both non-recurring and recurring costs should be permitted to transition to the health broadband services program without undergoing a new competitive bidding process.

As a Pilot program participant, I would recommend a transition to the new health broadband services program using the incumbent service providers if the Pilot program so chooses. The Service Provider's service and reliability should be well known at the time of the Pilot project's expiration. This transition would be conditional on metrics which might include percentage of network downtimes, cost escalation, the ability to scale services upward to accommodate growth of the health care providers.

V. Eligible Health Care Providers

113. The Commission previously determined that it does not have the authority to expand the list of eligible health care providers set forth in section 254(h)(7)(B).⁶⁸ This section defines "health care provider" as: (1) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (2) community health centers or health centers providing health care to migrants; (3) local health departments or agencies; (4) community mental health centers; (5) not-for-profit hospitals; (6) rural health clinics; and (7) consortia of health care providers consisting of one or more entities described in clauses (1) through (6).⁶⁹ We seek comment below on several proposals to expand the specific facilities that can be funded, consistent with the current statute. We also seek comment on whether there are any providers not identified below that should be eligible for support, consistent with the provisions of section 254(h)(7)(B).

Based on Pilot Program experience, there are several providers which should be included in the list of eligible entities: Primary Care Physicians for all services, other physicians for HIE/HITECH applications with Internet/NHIN; For Profit Hospitals and clinics in rural areas, underserved or un-served areas (for the last two Rural and Urban) where none other exists. The current eligibility lists excludes health care providers which are indispensable to health care delivery in these areas.

D. Skilled Nursing Facilities

122. We propose that non-profit skilled nursing facilities be considered eligible for rural health care support under the category of "not-for-profit hospitals."⁷⁰ Skilled nursing facilities provide some of the same post-acute services that are traditionally provided at hospitals, such as the management, observation, and evaluation of patient care.⁷¹ As noted by the National Broadband Plan, under the changing technological landscape of rural health care, services are no longer clearly divided into traditional delivery models.⁷² The CDC reports that the number of acute care facilities has decreased, and services traditionally provided in hospital settings are increasingly performed at non-acute and post-acute care

⁶⁸ 2003 Report and Order and FNPRM, 18 FCC Rcd at 24555, para. 16; *Changes to the Board of Directors of the National Exchange Carrier Association, Inc., Federal-State Joint Board on Universal Service*, CC Docket Nos. 97-21 and 96-45, Sixth Order on Reconsideration in CC Docket No. 97-21 and Fifteenth Order on Reconsideration in CC Docket No. 96-45, 14 FCC Rcd 18756, 18786, para. 48 (1999) (*Fifteenth Order on Reconsideration*); *Universal Service First Report and Order*, 12 FCC Rcd at 9118-19, paras. 655-56.

⁶⁹ 47 U.S.C. § 254(h)(7)(B).

⁷⁰ See *id.* § 54.601(d).

⁷¹ Dept. of Health & Human Servs., Ctrs. for Medicare and Medicaid Servs., "Medicare Coverage of Skilled Nursing Facility Care," at 1 (2007), available at <http://www.medicare.gov/publications/pubs/pdf/10153.pdf>.

⁷² See National Broadband Plan at 200-02; see also Internet2 June 25, 2010 *Ex Parte* Letter, at 4.

facilities.⁷³ Skilled nursing facilities are an example of this trend.⁷⁴ Specifically, due to advances in telemedicine, in many instances patients no longer need to be transferred to hospitals for treatment because they can receive the same or similar treatment at a skilled nursing facility.

There should be a provision for For-Profit Skilled Nursing Facilities in rural counties of states where there are no non-profit facilities. This is the same example as the Non Profit Hospitals, located in rural areas, being bought by For-Profit companies.

VI. ANNUAL CAPS AND PRIORITIZATION RULES

130. For the health infrastructure program, we seek comments on how to prioritize funding in the event projects apply and qualify for funding in any funding year that collectively exceed the proposed \$100 million cap. For example, one method for prioritizing projects could be based on the following factors: (1) total number of rural health care providers in the proposed network; (2) total number of health care providers (both urban and rural) in the proposed network, and (3) the combined HPSA scores for all urban health care providers in the proposed network. Under this method, USAC would give first priority to projects that have the highest number of eligible rural health care providers, not to exceed \$100 million in the aggregate and second priority to projects that have the highest number of health care providers (urban and rural). In the event projects have the same number of eligible health care providers in their proposed networks, they would be sub-ranked according to the number of rural health care providers in the proposed network. If further sub-ranking is required, projects would be ranked according to the aggregate HPSA scores of the urban health care providers in the proposed network. Other ways to prioritize projects could be to consider the relative size of the patient base or population density of the area served by the health care providers, or to consider measures such as the cost per served population or other factors that demonstrate the most cost effective use of funds. We seek comment on these or other methods that commenters may suggest for prioritizing project funding. Commenters recommending the use of one prioritization method over another should explain the basis for such prioritization, and explain how the prioritization system would work.

The focus of the broadband service should be not only on rural but underserved and un-served areas in a state. South Carolina has 75% of its counties in rural areas. The annual income in these counties is also low. The preponderance of service areas will therefore be in rural, underserved areas. However there are a number of sites which the PSPN would like to connect, we cannot use the federal program due to the eligibility requirements. These sites are in urban areas, but regardless are in areas of those counties which are un-served. First, states with the greatest number of sites in rural or underserved urban areas should be given priority. Secondly, a formula using HPSA or RUCA codes to determine rurality should be devised and used to allow including areas not currently eligible. This in tandem with the number of rural and urban underserved areas may determine the prioritization of the project.

B. “Meaningful Use” Criteria

142. The National Broadband Plan suggested that the Commission should condition receipt of rural health care support on providers’ compliance with the HHS meaningful use requirements after a certain period of time, such as three years. We recognize that any new compliance obligations may impose burdens on health care providers, and that these burdens may be more significant for rural providers. At the same

⁷³ William R. Jarvis, “Infection Control & Changing Health Care Delivery Systems,” 7 Emerging Infectious Diseases 170 (2001), available at <http://www.cdc.gov/ncidod/eid/vol7no2/jarvis.htm>.

⁷⁴ Dept. of Health & Human Servs., Ctrs. for Medicare and Medicaid Servs., “Medicare Coverage of Skilled Nursing Facility Care,” at 1 (2007), available at <http://www.medicare.gov/publications/pubs/pdf/10153.pdf>.

time, the goals reflected in the HHS meaningful use requirements are important, and there may be benefits both to providers and the federal government in aligning policies to the extent feasible. We seek comment on whether and how the Commission could align its performance measures with HHS's meaningful use criteria. We also seek comment on whether there are other federal criteria that we should consider adopting.

The FCC should consider a "Broadband Meaningful Use (BMU)" Stimulus Program aimed at all Providers which would include physicians and for-profit hospitals that are not covered in the existing RHC programs. The BMU would be tailored after the ONC's EMR meaningful use program that has gained significant traction across the country. Incentivizing MD's to adopt broadband technology and dedicated healthcare networks will greatly facilitated exchange of patient data, telemedicine and telehealth activities.

X. PROCEDURAL MATTERS

A. Initial Paperwork Reduction Act Analysis

152. This document contains proposed new information collection requirements. The Commission, as part of its continuing effort to reduce paperwork burdens, invites the general public and the Office of Management and Budget (OMB) to comment on the information collection requirements contained in this document, as required by the Paperwork Reduction Act of 1995.⁷⁵ In addition, pursuant to the Small Business Paperwork Relief Act of 2002,⁷⁶ we seek specific comment on how we might "further reduce the information collection burden for small business concerns with fewer than 25 employees."

The entire process is arcane. If one is not fully initiated in the vocabulary, policies and procedures of the FCC and USAC, the process is extremely difficult. The guidelines are not complete enough and often paperwork which is done with the intention of being thorough and compliant, will open additional requirements by the participant creating additional need for information and resulting delays. The instruction should be clear, understandable, and as thorough (but not excessively wordy).

⁷⁵ Pub. L. No. 104-13.

⁷⁶ Pub. L. No. 107-198.